**FORM FOR INDIVIDUALIZED HEALTH CARE NEEDS ASSESSMENT**

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| **Applicant’s/Student’s Name:** |  | **Date of Review:** |  |
| **Center Name:** |  | **ID #:** |  |

**Interview Conducted By:** Telephone  In Person  Videoconference

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| **List/explain any reasonable accommodation, reasonable modification to policies, practices, or procedures and auxiliary aids and services to include effective communication supports/accommodations offered and/or provided during the applicant file review process (applicants), and/or completion of the health care needs assessment process (applicants/students). If not provided, please explain below.** See Form 2-03, Procedures for Providing Reasonable Accommodation, Reasonable Modification in Policies, Practices or Procedures and Auxiliary Aids and Services for Participation in the Job Corps Program. |
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In determining whether, in your professional judgment, the above named individual’s health care needs exceed the Job Corps Basic Health Care Responsibilities in Exhibit 2-4 and interfere with participation in the program, consider the following and respond accordingly.

If the above-named individual has a disability, identify RA/RM/AAS necessary to reduce or remove barrier(s) to enrollment or continued participation in Job Corps. Do not consider whether, in your view, a particular RA/RM/AAS is “reasonable.” That determination must be made by the center director or their designees.

Only qualified health professionals (i.e., CMHCs, physicians, TEAP specialists, or outside specialists, etc.) may conduct and sign the **Form for Individualized Health Care Needs Assessment** for their respective disciplines.

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| **1A. Complete if APPLICANT.** |
| **What is the applicant’s history and present functioning to support statement of health care needs? Complete sections below.** |
| **ETA 653: (**list affirmative responses and explanations provided on ETA 653 only) |
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| **Applicant file review summary:** (provide summary of all health, educational or other documents reviewed) |
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| **Chronic Care Management Plan (CCMP) Provider Form/Provider Documents:** **Does the applicant’s treating outside provider recommend applicant to enter Job Corps?**   Yes  No  Provider unable to provide recommendation (explain below)  Not applicable (no CCMP provided) |
| **Provide a summary of the CCMP and/or provider documents here.** |
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| **Remember: If you have a conflicting recommendation with the outside treating provider, summarize discussion with treating provider or indicate efforts to contact treating provider and summarize here.** |
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| **Applicant interview summary: Include current impressions from clinical interview. This may include, but not be limited to, a mini mental status exam, current level of functioning, and areas of strengths and weaknesses.** |
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| **1B. Complete if STUDENT.** |
| **What is the student’s history and present functioning to support statement of health care needs? Complete sections below.** |
| **Summary of student’s health record:** |
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| **Summary of health records from outside Job Corps:** |
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| **Summary of discussion with all involved treating providers:** |
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| **Summary of any additional information or observations provided by center staff:** |
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| **Summary of student interview:** |
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| **2. What are the functional limitations, specific symptoms, and/or behaviors of the individual that are barriers to enrollment or continued enrollment in Job Corps at this time?** |
| |  |  |  |  | | --- | --- | --- | --- | |  | Avoidance of group situations and settings |  | Difficulty with sleep patterns | |  | Difficulty coping with panic attacks |  | Difficulty with social behavior, including impairment in social cues and judgment | |  | Difficulty managing stress |  | Difficulty with stamina | |  | Difficulty regulating emotions |  | Impaired decision making/problem solving | |  | Difficulty with communication |  | Interpersonal difficulties with authority figures and/or peers | |  | Difficulty with concentration |  | Organizational difficulties | |  | Difficulty handling change |  | Sensory impairments | |  | Difficulty with memory |  | Uncontrolled symptoms/behaviors that interfere with functioning (specify below) | |  | Difficulty with self-care |  | Other (specify below) |   *Note: This list is not all inclusive. These are suggestions for your use and you may need to consider functional limitations, symptoms, and/or behaviors beyond those identified on this list.* |
| **Specify additional functional limitations, symptoms, and/or behaviors for medical or behavioral health conditions if applicable:** |
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| **3. What are the health care management needs of the individual that are barriers to enrollment or continued participation in Job Corps at this time?** |
| Complex behavior management system required  Complex full mouth reconstruction/rehabilitation  Daily assistance with activities of daily living required  Frequency and length of treatment  Hourly monitoring required  Medical needs requiring specialized treatment to which individual would not have access  Out of state insurance impacting access to required and necessary health care  Severe medication side effects  Therapeutic milieu required  Other (specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Brief narrative on why the barrier(s) are checked above:** |
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| **4.** | **Based on your review of the individual’s health care needs above, does the named individual have health care needs beyond what the Job Corps health and wellness program can provide as defined as basic health care in Exhibit 2-4: Job Corps Basic Health Care Responsibilities?** *[Please mark one below.]* |
|  | 1. In my professional judgment, the individual’s health care needs exceed the Job Corps Basic Health Care Responsibilities in Exhibit 2-4.   ***If this box is checked, please proceed to question #5 below.*** |
|  | 1. In my professional judgment, the individual’s health care needs do not exceed the Job Corps Basic Health Care Responsibilities in Exhibit 2-4, but they do require community support services which are not available near center. Applicant should be considered for center closer to home where health support and insurance coverage are available.   ***If this box is checked, please proceed to question #5 below.*** |
|  | 1. In my professional judgement, the individual’s health care needs do not exceed the Job Corps Basic Health Care Responsibilities in Exhibit 2-4.   *If this box is checked, then you* ***do not*** *need to complete the remainder of this assessment, and the center will assign the applicant a start date or the student will continue enrollment.* *Retain all the paperwork included in completing this assessment, including all documentation that was reviewed, within the applicant’s or student’s Health Record.* |

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| **5**. | **Consideration of Reasonable Accommodation, Reasonable Modification in Policies, Practices or Procedures, and Auxiliary Aids and Services** | | | | |
| Is the applicant or student a person with a disability (a physical or mental impairment that substantially limits one or more of their major life activities)?   * *If no, skip to #6 to recommend denial for an applicant or MSWR for a student.* * *If no and recommending an alternate center for an applicant go to #7(a and c).* * *If yes, then continue to Post-Health Care Needs Assessment Disability Accommodation Review.* | | Yes |  | No |  |

**Post–Health Care Needs Assessment Disability Accommodation Review**

*Qualified Health Professional Responsibilities*

If the individual has a disability, the qualified health professional, in collaboration with the Disability Coordinator, completes the process and information below to explore the available RA/RM/AAS possibilities to reduce or remove the barriers to enrollment or to remaining in the program for a particular student/applicant with a disability. Ultimately, the qualified health professional is responsible for determining whether RA/RM/AAS would eliminate or sufficiently reduce the barriers to enrollment.

*STEP 1*

*Qualified Health Professional Instructions*

**In the table below, identify possible RA/RM/AAS and check the boxes to the left-hand side of the RA/RM/AAS table below. If there are other RA/RM/AAS that can potentially reduce this applicant’s/student’s barriers to enrollment or to remaining in the program, insert in the OTHER section for each identified functional limitation.**

Here are some possible examples of RA/RM/AAS that could eliminate or reduce the barriers. *Important: The items in the table are merely suggestions of possible RA/RM/AAS that may eliminate or reduce the barriers in a given case. You should be flexible and creative in working with the applicant or student to consider any other potential options that would be effective to reduce or eliminate the barriers to enrollment or to remaining in the program.*

*STEP 2*

*Interactive Process Instructions*

Then, either the qualified health professional or the Disability Coordinator initiates an interactive process with the qualified individual with a disability to discuss the RA/RM/AAS that the qualified health professional checked (or suggested) in STEP 1 above and (i.e., identifies the precise limitations resulting from the disability) and potential RA/RM/AAS that could overcome those limitations. The qualified health professional or the Disability Coordinator **documents whether the applicant/student accepts, declines, or there is agreement to modify the proposed RA or RM.**

**With respect to auxiliary aids and services (AAS), primary consideration must be given to the request of the applicant/student with a disability**.If the applicant/student or any other individual on the applicant’s/student’s behalf requests a RA/RM/AAS that potentially reduces the barriers to enrollment or to remaining in the program, the qualified health professional must consider these requests as well. If there is concern about the reasonableness of any related requested RA/RM/AAS, see Determining Reasonableness in Form 2-03.

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| **Avoidance of group situations and settings** | | **Accepts** | **Declines** |
|  | Allow student to arrive 5 minutes late for classes and leave 5 minutes early |  |  |
|  | Excuse student from student assemblies and group activities |  |  |
|  | Identify quiet area for student to eat meals in or near cafeteria |  |  |
| **OTHER** | | **Accepts** | **Declines** |
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| **Difficulty coping with panic attacks** | | **Accepts** | **Declines** |
|  | Allow student to designate a place to go when anxiety increases in order to practice relaxation techniques or contact supportive person |  |  |
|  | Provide flexible schedule to attend counseling and/or anxiety reduction group |  |  |
|  | Allow student to select most comfortable area for them to work within the classroom trade site |  |  |
|  | Provide peer mentor to shore up support |  |  |
| **OTHER** | | **Accepts** | **Declines** |
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| **Difficulty managing stress** | | **Accepts** | **Declines** |
|  | Allow breaks as needed to practice stress reduction techniques |  |  |
|  | Modify education/work schedule as needed |  |  |
|  | Identify support person on center and allow student to reach out to person as needed |  |  |
| **OTHER** | | **Accepts** | **Declines** |
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| **Difficulty regulating emotions** | | **Accepts** | **Declines** |
|  | Allow breaks as needed to cool down |  |  |
|  | Allow flexible schedule to attend counseling and/or emotion regulation support group |  |  |
|  | Teach staff to support student in using emotion regulation strategies |  |  |
|  | Provide peer mentor/support staff |  |  |
| **OTHER** | | **Accepts** | **Declines** |
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| **Difficulty with communication** | | **Accepts** | **Declines** |
|  | Allow student alternative form of communication (e.g., written in lieu of verbal) |  |  |
|  | Provide advance notice if student must present to group and opportunity to practice or alternative option (e.g., present to teacher only) |  |  |
| **OTHER** | | **Accepts** | **Declines** |
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| **Difficulty with concentration** | | **Accepts** | **Declines** |
|  | Allow use of noise canceling headset |  |  |
|  | Reduce distractions in learning/work environment |  |  |
|  | Provide student with space enclosure (cubicle walls) |  |  |
| **OTHER** | | **Accepts** | **Declines** |
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| **Difficulty handling change** | | **Accepts** | **Declines** |
|  | Provide regular meetings with counselor to discuss upcoming changes and coping |  |  |
|  | Maintain open communication between student and new and old counselors and teachers |  |  |
|  | Recognize change in environment/staff may be difficult and provide additional support |  |  |
| **OTHER** | | **Accepts** | **Declines** |
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| **Difficulty with memory** | | **Accepts** | **Declines** |
|  | Provide written instructions |  |  |
|  | Allow additional training time for new tasks and hands-on learning opportunities |  |  |
|  | Offer training refreshers |  |  |
|  | Use flow-charts to indicate steps to complete task |  |  |
|  | Provide verbal or pictorial cues |  |  |
| **OTHER** | | **Accepts** | **Declines** |
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| **Difficulty with self-care** | | **Accepts** | **Declines** |
|  | Provide environmental cues to prompt self-care |  |  |
|  | Assign staff/peer mentor to provide support |  |  |
|  | Allow flexible scheduling to attend counseling/supportive appointments |  |  |
| **OTHER** | | **Accepts** | **Declines** |
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| **Difficulty with sleep patterns** | | **Accepts** | **Declines** |
|  | Allow for a flexible start time |  |  |
|  | Provide more frequent breaks |  |  |
|  | Provide peer/dorm coach to assist with sleep routine/hygiene |  |  |
|  | Increase natural lighting/full spectrum light |  |  |
| **OTHER** | | **Accepts** | **Declines** |
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| **Difficulty with social behavior, including impairment in social cues and judgment** | | **Accepts** | **Declines** |
|  | Assign mentor to reinforce appropriate social skills |  |  |
|  | Allow daily pass to identified area to cool down |  |  |
|  | Provide concrete examples of accepted behaviors and teach staff to intervene early to shape positive behaviors |  |  |
|  | Adjust communication methods to meet students’ needs |  |  |
| **OTHER** | | **Accepts** | **Declines** |
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| **Difficulty with stamina** | | **Accepts** | **Declines** |
|  | Allow more frequent or longer breaks |  |  |
|  | Allow flexible scheduling |  |  |
|  | Provide additional time to learn new skills |  |  |
| **OTHER** | | **Accepts** | **Declines** |
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| **Impaired decision making/problem solving** | | **Accepts** | **Declines** |
|  | Utilize peer staff mentor to assist with problem solving/decision making |  |  |
|  | Provide picture diagrams of problem-solving techniques (e.g., flow charts, social stories) |  |  |
| **OTHER** | | **Accepts** | **Declines** |
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| **Interpersonal difficulties with authority figures and/or peers** | | **Accepts** | **Declines** |
|  | Encourage student to take a break when angry |  |  |
|  | Provide flexible schedule to attend counseling and/or therapy group |  |  |
|  | Provide peer mentor for support and role modeling |  |  |
|  | Develop strategies to cope with problems before they arise |  |  |
|  | Provide clear, concrete descriptions of expectations and consequences |  |  |
|  | Allow student to designate staff member to check in with for support when overwhelmed |  |  |
| **OTHER** | | **Accepts** | **Declines** |
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| **Organizational difficulties** | | **Accepts** | **Declines** |
|  | Use staff/peer coach to teach/reinforce organizational skills |  |  |
|  | Use weekly chart to identify and prioritize daily tasks |  |  |
|  | Use assistive technology organization apps |  |  |
| **OTHER** | | **Accepts** | **Declines** |
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| **Sensory Impairments** | | **Accepts** | **Declines** |
|  | Modify learning/work environment to assist with sensitivities to sound, sight, and smells |  |  |
|  | Allow student breaks as needed |  |  |
| **OTHER** | | **Accepts** | **Declines** |
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| **Uncontrolled symptoms/behaviors that interfere with functioning** | | **Accepts** | **Declines** |
|  | Alter training day to allow for treatment |  |  |
|  | Allow passes for health services center outside of open hours to monitor symptoms |  |  |
|  | Reduce tasks and activities during CPP to not aggravate symptoms/behaviors |  |  |
| **OTHER** | | **Accepts** | **Declines** |
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| **OTHER ACCOMMODATIONS, MODIFICATIONS, AUXILIARY AIDS AND SERVICES** | | **Accepts** | **Declines** |
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| Complete this section if the qualified health professional, in collaboration with the Disability Coordinator, has been unable to identify any RA/RM/AAS appropriate to support this applicant/student to sufficiently reduce or remove the barriers to enrollment or to remaining in the Job Corps program. *Provide explanation/justification below. For example, the applicant/student has active psychotic symptoms that impact ability to benefit from any RA/RM/AAS at this time.* |
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| *Summarize any special considerations and findings as well as the applicant’s or student’s input related to* ***RA/RM/AAS ONLY****. For example, if the applicant/student does not wish to discuss RA/RM/AAS, document that information below.* |
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***Please Note: Job Corps cannot impose RA/RM/AAS upon an individual.***

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| **6.** | **Clinical and Disability Accommodation Process (DAP) Summary** |
| * 1. **Clinical Summary: Summarize information from the file, clinical interview and/or discussions with providers to support the health care needs assessment.** | |
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| * 1. **Disability Accommodation Process (DAP) Summary: If RA/RM/AAS were identified above, include a detailed explanation for why these supports would not sufficiently reduce the barriers to allow for enrollment or to remain in the Job Corps program.** | |
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| **7.** | **APPLICANT ONLY- IF RECOMMENDING AN ALTERNATE CENTER (if selected “b” in item 4)** |
| **Clinical and Disability Accommodation Process (DAP) Summary** | |
| * 1. **Clinical Summary: Summarize information from the file, clinical interview and/or discussions with providers to support the health care needs assessment.** | |
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| * 1. **Disability Accommodation Process (DAP) Summary: If RA/RM/AAS were identified above, include a detailed explanation for why these supports would NOT sufficiently reduce the barriers to allow for enrollment to YOUR center.** | |
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| * 1. **Document efforts to secure community support near center in the space below.** (Include name of organizations/facilities and specific individuals contacted and why access is not available near center.) | |
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| I attest that I have the necessary licensure, training, and clinical experience to complete this assessment, including experience conducting safety assessments and identifying treatment, intervention and care management needs related to the symptoms and behaviors of this applicant’s/student’s documented health conditions.  **Printed or Typed Name and Title of Qualified Health Professional Conducting the Assessment**  **Signature of Qualified Health Professional Conducting the Assessment Date**  **Signature of Second Consulting Qualified Health Professional Date**  ***if applicable*** |